

AGENDA
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

September 11, 1985

6:00 - 7:00 p.m.
Congressional Room

JOINT CAS/COD ADMINISTRATIVE BOARDS MEETING

Guest

Norman D. Mansfield
Director, Division of Financial Management,
NIH

Discussion Topic *

"Policy Implications of a Sustained Increase
in the Number of Investigator-Initiated
Grants"

7:00 - 7:45 p.m.
Capitol Room

JOINT CAS/COD ADMINISTRATIVE BOARDS RECEPTION

7:45 - 9:00 p.m.
Caucus Room

CAS ADMINISTRATIVE BOARD DINNER

September 12, 1985

8:00 a.m. - 12 Noon
Calvert Room

CAS ADMINISTRATIVE BOARD MEETING

Noon - 1:00 p.m.
Executive Room

JOINT ADMINISTRATIVE BOARDS LUNCHEON

*See background paper -- page ii

FUTURE POLICY IMPLICATIONS FOR THE NIH BUDGET

In the years immediately before 1978, the number of new and competing renewal research project grants funded by the NIH often varied widely from year to year as depicted in Figure 1.

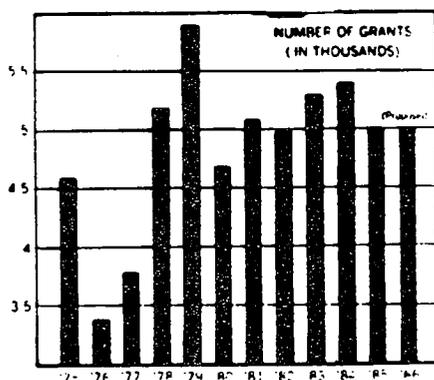


Figure 1

Former NIH Director Donald S. Fredrickson was among the leaders in the effort to convince the Congress of the desirability of funding an inviolable minimum number of new and competing project grants each year to provide stability for the biomedical research enterprise. Based on historic trends, 5,000 was originally proposed as the minimum number of project grants to be awarded; however, the budgetary constraints of recent years have transformed this "floor" into a "ceiling" on the number of new and competing renewal grants per year.

More recently, the biomedical community has argued to Congress that a target of 5,000 grants has no basis in terms of scientific quality and has, in fact, become restrictive in view of the increasing number of high quality grant applications being submitted. Thus, a congressional investment in real growth in order to capitalize on increasing research opportunities requires an appropriation sufficient to fund more than 5,000 competing grants per year. Such an investment was made in fiscal 1985 when Congress appropriated \$937.6 million to support approximately 6,500 competing grants at the NIH.

The biomedical research community, perhaps optimistically, assumed that this action meant a congressional commitment to provide sufficient funds to sustain a new "floor" of 6,500 competing project grants a year. It appears in retrospect that neither the biomedical research community nor the Congress fully projected nor understood the budgetary implications of 6,500 competing grants per year. The Office of Management and Budget (OMB) did recognize the rapidly accelerating costs associated with such a sustained increase in the number of grants and attempted to hold NIH to the "traditional" limit of 5,000 grants. In August, as part of the fiscal 1985 supplemental appropriation, Congress reaffirmed its commitment to real growth in the NIH budget by ordering that the fiscal 1985 appropriation be spent to fund at least 6,200 competing project grants and 533 center grants.

This resolution of the deadlock over the number of NIH grants for fiscal 1985 has produced a cohort of new grantees whose second and third years must be supported in fiscal 1986 and 1987 regardless of how many new grants are awarded in these years. It would be most unfortunate if Congress were to respond to this need for additional funding by a return to the pre-1978 solution of reducing the number of new grants in future years.

Four scenarios are possible. First is the solution proposed by OMB; that is, the cost of such an increase is too great and, therefore 6,500 grants cannot be allowed. The Congress has already rejected this option. Second would be to freeze the amount of funds appropriated in fiscal 1986 at the fiscal 1985 level. The increased amount of funds needed to support the continuing grants plus the rising costs of the grants themselves would mean a precipitous drop in the number of competing grants awarded in fiscal 1986. Third would be to provide for enough additional funds above fiscal 1985 to pay for 5,000 competing grants in fiscal 1986. Fourth would be to provide a substantial increase in funds to permit a continuation of the "new baseline" of between 6,000 and 6,500 grants in FY86 and 87. At present it is unclear which of the latter three options Congress is prepared to support.

A final point needs to be addressed. The NIH budget experienced minimal real growth during the 1970s. In order to sustain even 5,000 fully paid grants with a steadily increasing cost per grant, has meant that R01 grants have consumed an increasingly large portion of both the extramural portfolio and the NIH budget since 1977 (Figure 2). Any discussions of future budget

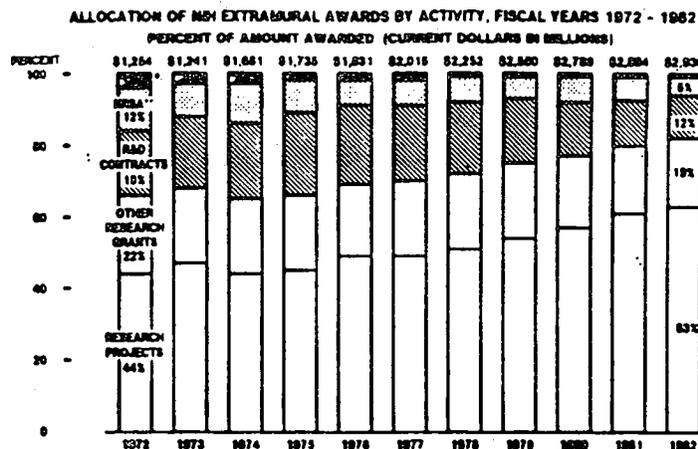


Figure 2

policy with regard to R01 grants also must take into consideration the implications of these decisions on the other budget mechanisms, such as research training grants, R&D contracts, and the intramural program.

Our discussion Wednesday evening with Dr. Mansfield will include the actual projected costs of a sustained increase in the number of competing project grants and the implications of such costs for the NIH budget as a whole.

AGENDA
 COUNCIL OF ACADEMIC SOCIETIES
 ADMINISTRATIVE BOARD

September 11-12, 1985

I. Report of the Chairman

II. ACTION ITEMS

- A. Approval of the Minutes from the June 19-20, 1985 Meeting of the CAS Administrative Board Y 1
- B. Membership Application: Surgical Infection Society Y 11
- C. CAS Nominations for Distinguished Service Member Y 13
- D. Commentary on the GPEP Report B 49
- E. Report of the Committee for the Governance and Management of Institutional Animal Resources B 70
- F. Research Facilities Construction Legislation B 62
- G. Investor Owned Teaching Hospital Participation in COTH . B 33
- H. Health Planning B 43
- I. Proposed Revision of GSA Rules and Regulations B 21
- J. Revision of AAMC Policies and Procedures for the Treatment of Irregularities in the Admissions Process. B 23
- K. The Independent Student Issue B 40

III. DISCUSSION ITEMS

- A. Medical Student Alternative Loan Program B 84
- B. Transition to Graduate Medical Education Y 14
- C. 1986 CAS Spring Meeting Plans Y 24

IV. INFORMATION ITEMS

- A. CAS Annual Meeting Program Y 25
- B. Update on the Fuqua Task Force and AAMC Research Policy Committee Y 26
- C. Ad Hoc MCAT Review Committee B 85
- D. Ad Hoc Committee on Faculty Practice B 86
- E. Research and Flexner Awards B 90

Y = Yellow CAS Agenda Book

B = Blue Executive Council Book

MINUTES
COUNCIL OF ACADEMIC SOCIETIES
ADMINISTRATIVE BOARD

June 19-20, 1985
Washington Hilton Hotel
Washington, D.C.

PRESENT: Board Members

Virginia V. Weldon, Chairman
David H. Cohen
William F. Ganong
Robert L. Hill
A. Everette James, Jr.
Joseph E. Johnson, III
Douglas E. Kelly
Frank G. Moody
Frank M. Yatsu

Staff

Robert Beran*
Janet Bickel*
Melissa Brown
Christine Burris
John A.D. Cooper*
James Erdmann*
Robert Jones*
Thomas J. Kennedy*
Richard Knapp*
Mary Littlemeyer*
David B. Moore
John F. Sherman
Elizabeth M. Short
August G. Swanson*

Guests

J. Robert Buchanan*
Robert Heyssel*
Richard Janeway*
Donald G. Langsley
Richard E. Wilbur

* Present for part of meeting

- I. The CAS Administrative Board met in joint session with the administrative boards from the COD, COTh, and OSR at 6:00 pm, Wednesday, June 19, 1985. Dr. Richard Janeway delivered the Chairman's Report, which summarized the sequence of events leading to the Executive Committee's position on S. 1158, the Dole-Durenberger bill on financing graduate medical education with Medicare funds. This was followed by the President's Report from Dr. John A.D. Cooper, who reviewed a number of other current legislative initiatives.

The main speaker for the evening was Representative Don Fuqua (D-FL), chairman of the House of Representatives Task Force on Science Policy, who outlined his views on the Task Force's study and its implications for biomedical and biobehavioral research. He began by saying that although his committee does not have jurisdiction over the NIH and ADAMHA, it does have a major responsibility for the direction of national science policy, which in turn affects all research in this country. Mr. Fuqua noted the importance of the Bush Report, written in

1945, as the rationale for the federal government's support of a "diverse and evergrowing research effort," and he stated the intention of the Task Force to determine whether this rationale is relevant to the present and future. He acknowledged the increasing role that science and technology play in our lives and contrasted this with the necessity of taking "a careful look at how all our budget categories are serving the nation's needs...." A fundamental question, according to Mr. Fuqua, is "whether or not the mechanisms and funding levels which have gradually evolved constitute the optimum approach to our government investment in science and engineering."

Mr. Fuqua stated that the scope of the Task Force's study is limited to those issues related to government support of basic and applied research. He emphasized that a number of the policy questions on the Task Force agenda are particularly relevant to biomedical research. As an example, he indicated that the Task Force will be particularly attentive to the issue of peer review as "an institutional mechanism for judging excellence." The study will also examine science education, but only at the graduate and postdoctoral levels.

Mr. Fuqua concluded his remarks by briefly summarizing some of the comments made by NIH Director Dr. James Wyngaarden before the Task Force on the subject of the changes that have occurred generally in biomedical research and specifically in the goals of the NIH. Dr. Wyngaarden noted that the increased competition for grants appears to have resulted in a subtle shift from a philosophy of investment in science and researchers to one of procurement, and he pondered what negative effects such an attitudinal shift might have on creativity in science. Dr. Wyngaarden also indicated that while the NIH has placed increasing emphasis on the strategy of disease prevention and on the application of research results to the practice of medicine, there is still a strong commitment to basic research, which currently receives more than 60 percent of the NIH budget.

II. BUSINESS MEETING

A. ACTION ITEMS

1. The minutes of the April 3-4, 1985 meeting of the CAS Administrative Board were approved as submitted.
2. 1985 CAS Nominating Committee

Dr. David Cohen, chairman of the CAS Nominating Committee, reported that the committee met by conference call on May 24, 1985. The Committee selected the following slate of nominees for membership on the CAS Administrative Board to be presented at the Annual CAS Business Meeting in October:

CHAIRMAN-ELECT

Frank G. Moody, M.D., Society of Surgical Chairmen,
Houston, TX

BASIC SCIENCES

(For a three-year term)

Joe Dan Coulter, Ph.D., Society for Neuroscience,
Iowa City, IA

(For a one-year term)

Gordon I. Kaye, Ph.D., Association of Anatomy Chairmen,
Albany, NY

CLINICAL SCIENCES

(For three-year terms)

Gary W. Hunninghake, M.D., American Federation for
Clinical Research, Iowa City, IA

Ernst R. Jaffe, M.D., American Society of Hematology,
Bronx, NY

ACTION: The CAS Administrative Board unanimously endorsed the Nominating Committee's slate of candidates.

Dr. Elizabeth M. Short informed the Board that Dr. Joseph Johnson's term as the fourth CAS representative on the Executive Council expires this year and that the Board must nominate someone to succeed Dr. Johnson. Dr. William F. Ganong was nominated for a three-year term on the Executive Council. Dr. Ganong reminded the Board that his term on the Board expires in 1986, and he inquired whether he was therefore eligible to serve on the Council. Dr. August G. Swanson informed the Board that the CAS Rules and Regulations provide for individuals elected as representatives to the Executive Council to retain ex officio membership on the Board.

ACTION: The CAS Administrative Board unanimously endorsed the nomination of William F. Ganong, M.D., to represent the Council of Academic Societies on the AAMC Executive Council.

3. Commentary on the GPEP Report

Dr. Virginia V. Weldon summarized the background leading to the draft of the GPEP commentary presented for the Board's consideration. Dr. Douglas Kelly, who chaired the joint CAS-COD working group that produced the commentary, indicated that both the CAS and COD representatives on that group were in general agreement with the content of the report. He stated that the draft contained the major points that the CAS had identified and that the only thing needed now was some final editing to provide more continuity to the narrative. Dr. Kelly noted that the COD members of the group had agreed to leave final editing to him. Dr. Kelly also acknowledged

contributions of the staff, particularly Mary Littlemeyer, in putting together the current draft.

Dr. Kelly outlined the two options available for distribution of the report. If both the CAS and COD boards agree to the draft, it can be forwarded to the Executive Council in September for approval as an AAMC document. The alternative would be to distribute the commentary to the constituent societies and to the schools (via the deans) as a CAS-COD document. Dr. Kelly urged that the report be distributed before the institutional curriculum committees begin their work in the fall. Dr. Swanson acknowledged that there was concern about the timing of the document's release with regard to the actions being considered by various institutions, but he stressed the significance of the commentary emerging as a consensus document from the Association. He also noted that the distribution would have to be limited to within the two councils if the document does not receive Executive Council approval.

Dr. Swanson proposed that if the CAS and COD boards could reach consensus on the main body of the document, then the final editorial work could be done and a final draft could be submitted to the Executive Council in September. If the Executive Council endorses the document at that time, it could be printed and ready for distribution by mid-October. Such a schedule would also permit distribution of the document at the Annual Meeting.

The Board also discussed the format for the final document and agreed that an effort should be made to design a publication that bears some resemblance to the original GPEP report. It was noted that the commentary's brevity might preclude a glossy format. Another suggestion was that different type faces be used to distinguish between the conclusions of the original GPEP report and the comments of the working group. The Board briefly discussed the content of the commentary and recommended several changes of wording to clarify the meaning of the working group.

ACTION: The CAS Administrative Board voted unanimously to approve the commentary on the GPEP Report prepared by the joint CAS-COD working group. The Board further directed Dr. Kelly to make final editorial changes, and requested that the document be submitted to the Executive Council for approval in September, with the intent that the document will be printed and distributed by mid-October.

4. Proposed charge for the AAMC ad hoc Research Policy Committee

Dr. Weldon reviewed the proposed charge developed by staff for the ad hoc Research Policy Committee. She noted that the charge called for a broad ranging agenda that would go beyond the issues being considered by the House Task Force on Science Policy. Dr. Weldon also informed the Board that Dr. Edward N. Brandt, former Assistant Secretary of Health

and current chancellor of the University of Maryland at Baltimore, has agreed to serve as chairman of the committee.

The Board discussed various ways in which the committee might interact with the House Task Force. Dr. Sherman pointed out that the jurisdiction of the House Committee on Science and Technology, which is the parent committee for the Task Force, is limited to the National Science Foundation in the area of biomedical research. This may limit a thorough understanding by the committee of issues unique to biomedical research, and admittedly, there is little expertise in this area on the part of the committee staff. Dr. Sherman noted, however, that AAMC staff have held several discussions with the committee staff, who have shown a ready acceptance of input from the biomedical community.

Dr. Short noted that AAMC staff were monitoring the hearings being held by the Task Force. She also explained that the AAMC would have a witness testifying before the Task Force in July on the subject of manpower and training.

The Board discussed the possibility of contact between other Board members or CAS representatives and members of the Task Force; e.g., inviting Task Force members to academic medical centers within their districts. Dr. Sherman agreed, noting that the Congress is usually driven by short-term considerations, but that this is a relatively long-term issue that will require frequent reiteration of the concerns and interests of biomedical scientists.

ACTION: The CAS Administrative Board approved the proposed charge for the AAMC ad hoc Research Policy Committee.

5. NIH Reauthorization

Dr. Thomas J. Kennedy described the administration proposal for legislation to renew the authority for certain NIH programs. He explained that the bill had been held up by the Office of Management and Budget, which prevented it from being introduced. Dr. Kennedy noted that the AAMC could support the administration's proposal. In the past, the AAMC has advocated simple renewal of the legislative authorities for the cancer and heart institutes and for NRSA training. The administration proposal essentially ignores these authorities with the intent to operate these programs under the general authority of section 301 of the Public Health Service Act.

Dr. Kennedy also outlined the status of the current House and Senate versions of NIH reauthorization legislation, both of which are virtual clones of the bill passed by the Congress last October and subsequently vetoed by the President. He noted that both bills are on a "fast track"; the House passed H.R. 2409 by a unanimous voice vote under suspension of the rules on June 17, and Senator Hatch introduced his bill, S.

1309, and reported it out of committee without hearings on June 19.

The Board discussed the various strategies that might be used to oppose the Senate and House bills. Drs. Kennedy and Sherman detailed the four points at which the NIH legislation might be stopped. First would be to block final passage by the Senate, either by keeping the bill off the floor or defeating it if it comes to a vote. Next would be to stalemate the bill in conference. This is a possibility because the two versions differ in a few, but significant, areas; the House bill has a nursing institute while the Senate version does not, the House has one-year authorizations while the Senate is for three years, and the Senate authorization ceilings for appropriations are lower than those of the House. Third would be a presidential veto of the bill if Congress passes a compromise measure, and fourth would be to sustain a presidential veto. With regard to the last point, Representative Waxman maintains that he has sufficient votes to override a veto; the situation is less clear in the Senate.

Staff suggested that the two most feasible junctures for action would be when the bill is in conference -- at which time the White House and the Office of Management and Budget may actively lobby for changes -- and to sustain a veto. It was decided that the best course of action for the AAMC would be to let the administration take the lead in opposing the bill, and to be prepared to work to sustain a veto, if necessary.

ACTION: The CAS Administrative Board endorsed the substance of the administration's proposed NIH bill.

6. Report of the AAMC ad hoc Committee on the Institute of Medicine Study of the Structure of the NIH

Dr. Kennedy reviewed the final draft of the report on the IOM study of the NIH. He noted that the report generally supports the IOM study, although it does disagree with a few points. The AAMC committee felt that the IOM study should have been more explicit in its opposition to new institutes, should have tackled much more directly the conflict between congressional directives and the need for scientific freedom, and should have had more praise overall for the NIH.

The Board also discussed the distribution of the committee's report. Dr. Sherman indicated that the question of whether the AAMC staff should meet with the IOM has not been resolved.

ACTION:

The CAS Administrative Board voted to endorse the report of the ad hoc Committee on the IOM Study of the Structure of NIH. The Board also recommended that the distribution and use of this report be discussed by the Executive Council, particularly with regard to the communication of the Association's concerns to the IOM.

7. AAMC Faculty Practice Survey

Dr. Weldon reviewed the background for the Faculty Practice Survey. She noted that the COD had surveyed all medical school deans, 115 hospital directors, and over 625 department chairmen and faculty. The question, upon looking at the staff's preliminary report of the survey results, was whether the AAMC should appoint a task force to review the survey and its implications for the constituency, particularly focusing on those issues where the AAMC might be helpful to the institutions. Dr. Short noted that such a task force could serve as a steering committee to determine the Association's role with regard to the key governance issues for faculty practice and how it relates to the academic mission.

The Board agreed that such a task force would be useful. Dr. Weldon pointed out that it would provide an opportunity for the constituents to learn about what is being done in other parts of the country. The current and future implications of practice plans on the relationship between the basic and clinical science departments were also felt to be appropriate topics for task force discussion.

ACTION:

The CAS Administrative Board voted to recommend that the Executive Council appoint a task force on faculty practice.

B. DISCUSSION ITEMS

1. NBME Change to Comprehensive Part I and Part II Examinations

Dr. Swanson reminded the Board of the actions taken by the National Board of Medical Examiners at its general meeting regarding the modification of its Part I and Part II examinations. The Board discussed what effect this would have on faculty dependence on national board examinations in evaluating the curriculum. The Board also discussed the implications of the modifications proposed for the score reporting procedures, which would provide one score covering all disciplines for each part. Dr. Swanson told the Board that the COD planned to discuss this issue further during the Annual Meeting. The Board discussed the possibility of having one or two deans meet to share their concerns with the Board. Dr. Swanson said he would follow the COD's progress on this issue.

2. Investor Owned Teaching Hospitals

The Board discussed whether for profit hospitals should be given membership in the Council of Teaching Hospitals.

Dr. Weldon noted that the COTH will bring this question to the Executive Council in September. The Association is currently seeking a legal opinion from the Internal Revenue Service on whether the admission of for profit institutions would change the tax status of the AAMC. Dr. Weldon said that the COTH will recommend that investor owned hospitals be allowed to join the AAMC. The Board discussed whether such memberships will have any qualifications. Dr. Sherman stated that if investor owned hospitals are granted membership, it would be a full, unqualified membership. The general consensus of the CAS Board was that, although there are still a number of unresolved questions, for-profit teaching hospitals should be admitted to the COTH.

3. Association Position on Financing Graduate Medical Education

Dr. Richard Janeway, accompanied by Drs. Buchanan, Heyssel, Cooper, and Knapp, led a discussion of the Executive Committee position with regard to the Dole-Durenberger proposal to modify the current system of Medicare funding for graduate medical education. Dr. Janeway explained that he wanted to provide an opportunity for input from each of the three Councils in response to the Executive Committee's action. He emphasized that this position in no way subverts the usual processes of the Association to establish a consensus opinion and may serve as a possible catalyst for the deliberations of the AAMC Committee on Financing Graduate Medical Education.

Dr. Janeway acknowledged the controversy concerning the decision to support funding to initial board eligibility or five years, whichever is less, and explained that such a position is consistent with the principle of board eligibility. In addition, this cutoff could be applied uniformly across all specialties and, therefore, lessen the possibility of legislation manipulating specialty distribution within the training environment. Dr. Janeway stressed that attempts to specify specialty distribution was viewed by the Executive Committee as more intrusive than a limitation on the number of years of training to be funded.

Dr. Janeway also noted that the Executive Council favored amending the Dole-Durenberger bill to enable training programs to bill for services of residents beyond their initial boards. Another Association amendment would exclude U.S. graduates of foreign medical schools as well as alien FMGs from receiving Medicare support for residency training and would propose a three-year phase-in to avoid disruption of care. Dr. Janeway stated that there was some concern about the constitutionality of a law that would deny funding to FMGs with permanent visas and U.S. FMGs.

There was discussion of the historical basis for the current system of subspecialty training in internal medicine being conducted separately from the three-year initial board eligibility program. Dr. Johnson agreed that the

Dole-Durenberger bill posed problems for the medical subspecialties. He pointed out, for example, that this bill would support nephrologists for only three out of the five years required for board eligibility, while it would fund urologists for all five years of their training. He also suggested that reimbursement of residents for services would probably favor surgical residents, who would be able to charge for specific procedures.

Dr. Johnson said that he partially agreed with the Petersdorf proposal to strengthen the mechanisms to control the numbers of residents in subspecialties, provided that this would be done by the residency review committees and the LCGME rather than the Congress. Dr. Buchanan noted that the AAMC Committee on Financing GME also was concerned about external agencies controlling residency distribution by specialty. Dr. Cooper reminded the group that Association policy, as stated in the 1981 Report on Graduate Medical Education, holds that the government is not the appropriate body to control the numbers or distribution of residencies.

Dr. Buchanan informed the Board that the AAMC Committee on Financing GME would meet in July and that he hoped that they would have a report drafted this summer. He noted that it would be useful for the Committee to have input from the Board on the other legislative proposals, particularly those from Quayle and Waxman, which offer major intrusions into the distribution of residents by specialty. The consensus from the Board's discussion of these bills was that the AAMC should oppose them.

4. Review of the MCAT Program

Drs. James Erdmann and Robert Beran discussed the growing concern on the part of the Association's staff that there may be problems or at least the perception of problems with the MCAT exam. They noted that a range of concerns had been reported in the past to the COD and CAS, and inquired whether the Association needed to take a comprehensive look at the MCAT. Dr. Swanson told the Board that the COD was going to recommend an ad hoc committee to examine the MCAT. The consensus of the CAS Administrative Board was to support the COD recommendation.

C. INFORMATION ITEMS

1. Ad Hoc Committee on Guidelines for Institutional Management of Animal Resources

Dr. Short described the committee formed by the Association to draft a set of generic institutional guidelines for the management and supervision of animal resources. She noted that this committee is a joint AAMC-AAU effort, which is appropriate because animal resources are often managed centrally by the university. The committee, which is scheduled to meet July 17, is chaired by Henry L. Nadler,

dean of Wayne State University School of Medicine, and William H. Danforth, chancellor of Washington University. Dr. Short said that the committee's report will be modeled after the 1981 institutional guidelines dealing with fraud in research in that it will outline how the process might be managed. She added that the report will come before the Board and the Executive Council for endorsement in September.

MEMBERSHIP APPLICATION
COUNCIL OF ACADEMIC SOCIETIES
ASSOCIATION OF AMERICAN MEDICAL COLLEGES

MAIL TO: AAMC, Suite 200, One Dupont Circle, N.W., Washington, D.C. 20036
Attn: Mr. David Moore

NAME OF SOCIETY: Surgical Infection Society

MAILING ADDRESS: Secretary, Surgical Infection Society
Jonathan L. Meakins, MD, DSc, FRCS(C)
Department of Surgery, McGill University
Royal Victoria Hospital, 687 Pine Avenue West
Montreal, Quebec H3A 1A1, Canada

PURPOSE:

See attached sheet

MEMBERSHIP CRITERIA:

See attached sheet

NUMBER OF MEMBERS: 257

NUMBER OF FACULTY MEMBERS: 229

DATE ORGANIZED: 17 May 1980

SUPPORTING DOCUMENTS REQUIRED: (Indicate in blank date of each document)

17 May 1980 1. Constitution & Bylaws

29-30 April 1985 2. Program & Minutes of Annual Meeting

(CONTINUED NEXT PAGE)

QUESTIONNAIRE FOR TAX STATUS

1. Has your society applied for a tax exemption ruling from the Internal Revenue Service?

X YES NO

2. If answer to (1) is YES, under what section of the Internal Revenue Code was the exemption ruling requested?

Section (501) (c) (3)

3. If request for exemption has been made, what is its current status?

X a. Approved by IRS
 b. Denied by IRS
 c. Pending IRS determination

4. If your request has been approved or denied, please forward a copy of Internal Revenue letter informing you of their action.
Attached

Basil A. Pruitt, Jr.
Basil A. Pruitt, Jr., MD, FACS
(Completed by - please sign)

August 6, 1985
(Date)

CAS NOMINATIONS FOR DISTINGUISHED SERVICE MEMBERS

In June 1980 the CAS Administrative Board established a policy whereby an individual would automatically be considered for nomination to the category of Distinguished Service Member in the AAMC if he or she has served as chairman of the CAS, chairman of the AAMC representing the CAS, or as a member of the CAS Administrative Board for two consecutive terms. Accordingly, the CAS Board should consider the following individual:

Robert L. Hill

CAS Chairman 1983-84

The sections of the AAMC Bylaws pertaining to Distinguished Service Membership and the current list of Distinguished Service Members from the CAS are shown below for reference.

AAMC Bylaws

I.2.B. - "Distinguished Service Members - Distinguished Service Members shall be persons who have been actively involved in the affairs of the Association and who no longer serve as AAMC representatives of any members described under Section 1."

I.3.E. - "Distinguished Service Members shall be recommended to the Executive Committee by either the Council of Deans, Council of Academic Societies, or Council of Teaching Hospitals."

CAS Distinguished Service Members

Robert M. Berne
F. Marian Bishop
A. Jay Bollet
Samuel L. Clark, Jr.
Carmine D. Clemente
Jack W. Cole
Ludwig W. Eichna
Ronald W. Estabrook
Harry A. Feldman
Patrick J. Fitzgerald

Robert E. Forster, II
Daniel X. Freedman
Rolla B. Hill, Jr.
John I. Nurnberger
Thomas K. Oliver
Hiram C. Polk
Jonathan E. Rhoads
James V. Warren
Ralph J. Wedgwood
William B. Weil, Jr.
Frank C. Wilson

TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

The attached issues paper was developed from an analysis by Dr. Norma E. Wagoner with the assistance of Drs. Jack Gardner, Jon Levine, and Paula Stillman at the request of the COD Administrative Board following a discussion of problems in the transition to graduate medical education at the June Board meeting. It represents an attempt by the leadership of the Group on Student Affairs (GSA) and the Group on Medical Education (GME) to assist the Association by more specifically identifying and describing the myriad of problems which have tended to be lumped together under the generic label of "the problem with residency selection" in many previous discussions of this issue (see Attachment I, pp, 22-23). The GSA-GME paper explicitly identifies issues in 3 key phases of the transition to graduate medical education. It attempts to clearly acknowledge the complexity and interrelatedness of the many facets of this process. It also suggests possible and partial solutions to some of the specific concerns identified.

The CAS Board should review this document and discuss whether it might serve as an agenda of issues for association consideration. Does the Board feel that these are the key issues? Are there others? Does this analysis help to provide a focus for further actions?

The COD Board is also discussing this paper, and plans to use it as a basis for a discussion by their entire Council at the annual meeting. Should the CAS Council also discuss this paper in October?

TRANSITION TO GRADUATE MEDICAL EDUCATION:
ISSUES AND SUGGESTIONS

I. Graduate Medical Education and the Selection Process

A. Issues

A number of recurring questions and concerns center around the selection process and the associated matches:

- o With the limitation in positions, do program directors need to begin to define the population to whom they will give major consideration in the selection process?
- o We have yet to see the impact of the for profit hospital corporations on the recruitment and selection of medical students for positions funded by those corporations in certain medical centers.
- o Does any organization have the right to prevent, restrict or constrain any groups of individuals from establishing their own match process? Will the for profit hospital corporations move in that direction?
- o The NRMP has been in continual evolution since the late 1950's; does the system need further revision to accommodate contemporary needs?

Consideration of these questions and concerns have led to the identification of the following problem list for the graduate medical education selection process:

1. Too much splintering of specialty interest groups into their own match processes: Colenbrander matches, military matches, Urology match, and individual hospital or specialties which operate outside the boundaries of any match process (the no-match group).
2. No uniformity of applications. Some programs use the uniform application, while others use one that has been developed by their own hospitals. This creates enormous pressures on students who may need to submit 30 to 50 applications to one, two, or more specialties.
3. Points of entry into graduate training are many and varied, leading to massive communication problems for all participants.
4. The algorithm and terminology of the NRMP are complex and not easily understood even by the most experienced.

5. In the competitive specialty programs, selection committees are insisting that candidates come for interviews (without any assurances) in order to be given consideration.
6. There is no composite information on available options through all forms of selection processes. This leads to difficulties in communication about entry points for postgraduate training. Each entity administering a match carries out its own form of advertising.

B. Suggestions

Short Term Changes

1. Request that NRMP review and evaluate current information that is being disseminated to program directors and students, including descriptions of the match algorithm and the types of positions offered.
2. There is a definite need for some entity (perhaps the AAMC) to develop comprehensive materials on the residency selection process. A prototype example might be the Medical School Admission Requirements handbook. Explore how this information can or should be communicated.

Long Term Changes

3. Consider a thorough examination and evaluation of the current NRMP process and staffing needs. The NRMP Board of Directors is the group with this responsibility. Perhaps the recently created advisory board could work with the NRMP to provide input from each specialty.
4. Consider development of centralized application service. While there is a uniform application, there is no agreed upon usage. If the program directors could be furnished a reduced administrative workload through such a service (e.g. AMCAS), the system could become sufficiently widely used to furnish a basis for the development of "traffic rules" (e.g. uniform dates).
5. Develop materials by specialty (including details of specific programs within each specialty) which could be sold at cost to students. Such materials should include the following types of information:
 - a. Types of candidates that each program seeks. If possible, a greater specificity about the range of backgrounds sought: LCME graduates only, East coast schools only, AOA, National Board Part I scores of 550 or better, etc. This could reduce the "shot-gun" approach to program selection which currently exists and could markedly reduce the work-load of all parties concerned. If a book of this type is to be developed,

program directors must be convinced that it helps them cut their own costs of communication, and reduces their work load.

- b. Range of stipend. This may become increasingly important as students amass high debts. Students will need to know if they can afford particular programs.
 - c. Range of benefits - malpractice insurance, health benefits, etc.
 - d. Expected background -- "desirable to have electives in....."
 - e. How the interview process is administered.
 - f. Whether they have special programs: primary care track, research track, and other special features of the program.
6. Have teaching hospital directors assume authority over the recruitment and selection procedures of the programs sponsored by their institutions. The diversity of specialties and the sheer number of programs (over 5,000) makes the achievement of uniform policies and procedures almost impossible. In addition, the development of useful information about institutions' programs for students would be simplified if reliable communications were established with the institutions that sponsor programs rather than with each program director. The AAMC has pressed for greater institutional responsibility for graduate medical education since the late 1960s. The assumption of authority over recruitment and selection policies and procedures by the directors of COH member hospitals, which provide more than 60 percent of residency positions, could set a precedent that other hospitals would follow.

II. Graduate Medical Education and the Clinical Curriculum

A. Issues

Another major dimension of the transition process is its impact on the clinical education of the medical student, as is evidenced by the following questions and concerns:

- o Do residency directors unduly influence the medical school curriculum now that students are being recruited and selected as early as the third year?
- o Are program directors suggesting (or even stating) to students that unless they take an elective in their hospital, they will not be interviewed or fully considered for a position?
- o Has the use of external examination scores (NBME Parts I and II) become a major selection factor, when it is known that

these scores measure only a small fraction of the attributes necessary for the practice of quality medicine?

A careful review of these and related questions lead us to the following delineation of problems in the clinical education of medical students:

1. Students seeking positions in the very competitive specialties (particularly the surgical specialties, but also, ophthalmology and emergency medicine) are reported to be taking three and four identical electives in the specialty area of choice at various hospitals in the hope of bettering their selection chances. This compromises the general professional education of the physician.
2. A good portion of the fall of the senior year is devoted to completing multiple applications and seeking interviews. There appears to be little interest in assisting the students by grouping interviews for traveling to a particular region of the country. Often times students must make multiple trips back to an area because of the inflexibility of the interview process.
3. The cost of travel associated with the selection process discriminates against less affluent students and, if incorporated in the approved educational costs, increases their indebtedness.
4. The focus on education and learning is being lost in the increasing emphasis on preparing for the residency selection process.
5. Schools are being forced to change their third year curricular structures to accommodate pressures on their students for early exposure to various specialties. Similar pressures in the fourth year are acting to distort elective programs as students undertake earlier specialization.
6. Earlier selection and preparation for selection are forcing premature decisions about career choices upon students.
7. Because low or average NBME scores may preclude a student from being interviewed, schools now need to furnish considerable time for students to prepare for and/or to provide support services to assist them in preparation for these examinations.
8. The pressure upon schools to place their graduates is causing a grade inflation problem, thus lessening the credibility of grades as a measure of competence.

B. Suggestions

Short Term Changes

1. Ask the program directors to work with the AAMC to facilitate communication with medical schools: traffic rules, general guidelines, uniform applications, interview time frames.
2. Undertake research to determine which selection factors provide the best residents. This may increase the quality of selection factors beyond those now currently being used.

Long Term Changes

3. Reduce the number of medical students commensurate with the reduction in residency positions.
4. Development of an examination of clinical skills which is both more comprehensive and more oriented to problem solving. Such an examination might well include a "hands on" performance evaluation.
5. Consider a fifth year of medical school. By the fifth year, students would have narrowed their specialty interest to three and would spend three months in each area. The three remaining months of that year would be devoted to a Match process with high quality evaluation techniques being utilized to provide maximum information about the students' skills, abilities and suitability for a particular professional area.
6. Consider extending medical school through four years of clinical education, incorporating residency training into the fourth, fifth, and sixth years of a pre M.D. program.

III. Graduate Medical Education and the Counseling Process

A. Issues.

A third series of questions and concerns exemplify another area affected by the transition: the role of Deans of Student Affairs and the problems of counseling in residency selection.

- o In transmitting information to program directors, should Deans of Student Affairs be a student advocate or a factual reporter? Do they have an obligation to see that all medical students have a graduate medical education position?
- o In times of more limited resources, Deans of Student Affairs are being asked to take on greater responsibilities in the residency placement process, including working with graduates who are one, two, or more years out of medical school. How far in time does institutional responsibility extend?
- o What responsibility does an institution have to develop a comprehensive advising system? Should such a system include financial planning and debt counseling since graduates may

have debts which are excessive in relation to residency salaries?

- o Advising is a demanding job and advisors need to have broad knowledge of programs, hospitals, specialties, understanding of selection factors and knowledge of financial matters. Is it realistic to expect our medical schools to expand the staffing for these advising functions?

These questions suggest the following problem areas which might be addressed:

1. In the past, medical students have usually been able to obtain a position in the specialty they wanted. Now, with fewer positions available, Deans of Student Affairs are being placed increasingly in the position of encouraging students to apply for two or three specialties. This emphasis on getting students placed, comes at the expense of the "career fit" counseling process.
2. A related problem with yet to be determined consequences is the possible effect of reduced funding for graduate medical education on the remuneration available and the possibility of significant variation in compensation levels.
3. Early Deans' letters for special matches often require supplemental letters for subsequent matches, compounding the administrative load.
4. Training new and or part-time Deans of Student Affairs in the development of counseling systems and in keeping up with changes in the selection process.
5. Advising the students who find themselves in difficult ethical dilemmas regarding match situations. The ethics of the marketplace appears to be prevailing, and the sense that anything goes is creating major problems with agreements about current procedural guidelines. This is particularly true for the unmatched student who is seeking a competitive specialty. When very few places are available, the temptation to cheat increases.
6. Helping students reduce the anxieties involved in a competitive selection process where their years of work may not achieve a result supportive of their career goals. This may contribute to a loss of idealism about the practice of medicine and about themselves as practicing physicians.

B. Suggestions

1. Offer a national institute where program directors, Student Affairs Deans, and selected students can meet to develop some strategies and goals for increasing the effectiveness of the selection process.

2. Develop a network of Deans of Student Affairs (computer bulletin board?) to provide a means for updating certain kinds of information. Such a network has been proposed by the NRMP for listing unfilled places throughout the year. This type of network might be extended more fully to provide a greater array of services through the NRMP office.

THE PRERESIDENCY SYNDROME: A RECENT CHRONOLOGY1983

- A. A presentation by Jack Graettinger (NRMP) at the Northeast GSA, Spring Meeting - 1983, was instrumental in beginning the most recent round of discussions regarding this set of interrelated problems.
- B. Howard Levitin (Yale) took the concerns of the NEGSA to the Thirteen School Consortium who through Dean Robert Berliner (Yale) wrote to Dr. Cooper requesting that the AAMC undertake a major initiative to develop solutions.
- C. The Council of Deans discussed this as an agenda item at their Scottsdale meeting (Spring 1983).
- *D. The AAMC decided to study the problem from the perspective of the program directors. Dr. Cooper (AAMC) wrote to the clinical societies within CAS asking of each society whether it had an established position on the matter of the selection of applicants into residency training programs.
- *E. A plan of action was discussed by The Executive Council (June, 1983). The GSA Steering Committee was charged with the preparation of a "White Paper."
- *F. As requested by the Executive Council, Joe Keyes wrote an analysis of the CAS responses for the Executive Council agenda, September, 1983. The Executive Council concluded that the Executive Committee of the AAMC should meet with officials of those clinical disciplines using early match dates. (See H, Below)
- *G. This problem area was the major topic of the CAS agenda at the AAMC Annual Meeting, Fall, 1983.
- H. Dec. 7, 1983; AAMC Executive Committee met with specialties operating outside NRMP. Libby Short (AAMC) designed for this special meeting a flow chart showing how the NRMP match could meet all of the objectives of those disciplines currently operating outside the match. Minutes of this meeting were circulated to all participants who were, in turn, asked to comment.

1984

- *I. The minutes of the Dec. 7, 1983 meeting were adjusted for these comments and were mailed to the Executive Council with the agenda for the January, 1984 meeting.
- J. The proposal developed by the Executive Council (September 1983) for an advisory committee to NRMP was vetoed by the AMA representative to the NRMP board. In late Spring, 1984, the advisory committee was approved, although it did not meet until Spring, 1985.
- K. Spring and Summer of 1984, Dr. Cooper and Dr. Graettinger appeared before the Boards of some of the specialties which operate outside the match with the request that they participate in NRMP; little response.
- *L. June, 1984, the CAS Administrative Board adopted a resolution supporting the position of a single match.
- *M. September, 1984, the AAMC Executive Council approved a modified form of that resolution.
- N. At the AAMC Annual Meeting, Fall, 1984, the Council of Academic Societies and the Council of Deans approved the Executive Council resolution.

1985

- O. At the Spring, 1985, CAS meeting, a planned discussion on GPEP developed into a discussion of early match problems.
- P. April, 1985, the Specialty Advisory Committee to the NRMP Board held its first meeting with Dr. Swanson representing the AAMC.
- Q. April, 1985, new LCME guidelines approved; "Functions and Structure of a Medical School" (See R., below).
- *R. Dean Arnold Brown (Wisconsin) requested further discussion at the Summer Meeting of the COD Administrative Board. The Board requested that AAMC Staff, GME officers, and GSA officers develop an Action Agenda for the September, 1985, meeting.

1986 CAS SPRING MEETING

The CAS will hold its 1986 Spring Meeting on March 26 and 27 at the Sheraton Washington in Washington, D.C. As in previous years, the first day will be devoted to a theme chosen by the Administrative Board. It is recommended that possible speakers also be identified at this time.

The following morning's session will include the CAS business meeting.

1985 CAS ANNUAL MEETING PROGRAM

The Annual Meeting program for Sunday, October 27, 1985, will consist of two 90 minute sessions, followed by a reception in the evening. The CAS Annual Business Meeting will be held on Monday, October 28.

SUNDAY, OCTOBER 27

PLENARY SESSION

1:30 - 3:00 p.m.

"Who Will Do Medical Research in the Future?"

Speakers:

Gordon N. Gill, M.D.
Professor of Medicine
University of California, San Diego
School of Medicine

John W. Littlefield, M.D.
Professor and Chairman of Pediatrics
Johns Hopkins University School of Medicine

3:00 - 3:30 p.m.

BREAK

3:30 - 5:00 p.m.

"Peer Review: A Crisis of Confidence."

Speakers:

Ruth L. Kirschstein, M.D.
Director
National Institute of General Medical
Sciences

Edward N. Brandt, M.D.
Chancellor
University of Maryland at Baltimore
and
Chairman, AAMC ad hoc Research Policy Committee

5:30 - 7:00 p.m.

CAS COCKTAIL RECEPTION

MONDAY, OCTOBER 28

1:30 - 5:00 p.m.

CAS BUSINESS MEETING

UPDATE ON FUQUA SCIENCE POLICY TASK FORCE AND
AAMC RESEARCH POLICY COMMITTEE

The House of Representatives Task Force on Science Policy conducted two sets of hearings this summer. The first hearings, which were held June 25 and 26, were entitled "Science in the Political Process," and were supposed to deal primarily with the three questions under this heading in the Task Force Agenda:

- How can the expert judgements of the scientists and the societal goals-oriented judgements of members of Congress effectively interact?
- At what levels should decisions be made by scientists, by members of Congress, and jointly?
- Under what circumstances should the Congress and/or the scientific community use criteria such as regional economic growth, specific health needs, and agricultural crop needs in making decisions for science policy?

Among the witnesses at these hearings were Dr. Robert Sproull, chairman of the Working Group on Institutional Renewal of the National Academy of Science Government-University-Industry Research Roundtable; Dr. John Silber, president of Boston University; and Dr. Robert Rosenzweig, president of the Association of American Universities.

Much of the discussion following the prepared statements deviated from the subject of the hearings to concentrate on the inequities created through the peer review system, which was characterized by members of the Task Force as an "old boy network." The Task Force also focused on an issue raised by Chairman Fuqua during his presentation at the June meeting of the Councils -- how can "emerging" institutions succeed in a system where only the rich get richer.

In July, the Task Force held six hearings on science manpower and education. Most of the schedule was devoted to engineering, but Dr. David Challoner, vice president for health affairs at the University of Florida, presented testimony on behalf of the AAMC related to research manpower in the biomedical sciences. Dr. Challoner stressed that the flexibility of the NIH and ADAMHA to adapt to the challenges of future research opportunities must be maintained. The Task Force also heard from Dr. Robert Hill, who described the NAS Committee on National Needs for Biomedical and Behavioral Research Personnel; and John Moore, deputy director of the National Science Foundation.

The AAMC ad hoc Research Policy Committee held its first meeting on August 8 and 9 in Washington. The membership of the committee is listed on the following page. During the first meeting, the committee discussed the goals of the federal research effort and research manpower and training. Two more meetings of the committee have been scheduled. On October 29 and 30, the committee will consider the research infrastructure and the research

awards system. On December 11 and 12, the committee will focus on federal funding for research and the formulation of federal research policy. It is expected that the committee's report will be ready for submission to the Executive Council in April 1986.

AAMC Research Policy Committee

Chairman:

Edward N. Brandt, M.D.
Chancellor
University of Maryland at Baltimore

Members:

Stuart Bondurant, M.D.
Dean
University of North Carolina at
Chapel Hill School of Medicine

Leon E. Rosenberg, M.D.
Dean
Yale University School of
Medicine

David H. Cohen, Ph.D.
Chairman, Dept. of Neurology
SUNY at Stony Brook School of
Medicine

Benjamin D. Schwartz, M.D., Ph.D.
Professor of Medicine
Washington University School of
Medicine

Robert E. Fellows, M.D., Ph.D.
Chairman, Dept. of Physiology and
Biophysics
University of Iowa College of
Medicine

David B. Skinner, M.D.
Chairman of Surgery
University of Chicago, Pritzker
School of Medicine

Thomas Q. Morris, M.D.
President
Presbyterian Hospital in the
City of New York

Peter C. Whybrow, M.D.
Chairman, Dept. of Psychiatry
University of Pennsylvania
School of Medicine

John T. Potts, M.D.
Chairman of Medicine
Massachusetts General Hospital

Ex-Officio:

Richard Janeway, M.D.
Chairman, AAMC
Dean
Bowman Gray School of Medicine

Virginia V. Weldon, M.D.
Chairman-Elect, AAMC
Associate Vice-Chancellor for
Medical Affairs
University of Washington School
of Medicine